levels were positive in their second-look. 70% of patients with residual tumors having the greatest diameter less than or equal to 2 cm had normal CA125 with a mean value of 21 u/ml. 42% of patients with tumors having the greatest diameter greater than 2 cm had normal CA125, while all the 8 patients with no macroscopic tumor during surgery had normal CA125 level. These results show that the residual tumor size found in the second-look was related to the serum CA125 level.

Conclusion As CA125 levels within normal limits gave more false negatives, the necessity of second-look surgery can not be judged by serum CA125 assay though elevated CA125 levels do predict the presence of tumor.

**2022-VA-1284-ESGO**

**INDOCYANINE GREEN AS A LEARNING TOOL FOR PARA-AORTIC LAPAROSCOPIC LYMPHADENECTOMY AFTER SENTINEL LYMPH NODE DETECTION IN OVARIAN CANCER**

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10.1136/ijgc-2022-ESGO.676

**Introduction/Background** Indocyanine green is being widely used in gynecology oncology; specially in sentinel node detection in endometrial cancer. New applications are being studied, as sentinel node detection in ovarian cancer.

**Methodology** We are performing indocyanine green laparoscopic sentinel node detection in a woman affected by ovarian cancer. She had been diagnosed after an anexectomy for a suspicious ovarian mass in another center. We inject indocyanine green in the infundibulopelvic and the ovaric ligament stumps through the abdominal wall.

**Results** After the detection of the sentinel nodes we perform the lymphadenectomy with the fluorescent camera on. We perceive the anatomical marks more clearly, the difference between the vessels and the lymphatic tissue became more individualized. Avoiding vessel injury is one of the challenges in the learning curve for para-aortic lymphadenectomy. Anatomical variations in the para-aortic region occurred in one third of the women.

**Conclusion** Indocyanine green is a useful tracer for sentinel node detection. We propose that it could be a learning tool for beginners in the lymphadenectomy technique and in cases of special difficulty, for example in anatomical variations.

**2022-RA-1288-ESGO**

**UNKNOWN OVARIAN NEOPLASM WITH RETROPERITONEAL INVOLVEMENT – METASTASIS OR TWO PRIMARY TUMORS? – CASE REPORT**

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10.1136/ijgc-2022-ESGO.678

**Introduction/Background** Proper diagnosis of abnormal ovarian masses determines the extent of surgical procedure and adjuvant chemo/radiation treatment. Occasionally, invasive, radiologic and laboratory tests are inconclusive and planning of upcoming steps in management requires individual approach. Detailed description of such cases in scientific literature could be beneficial for the management of similar occurrences.

**Methodology** 54 year old patient admitted to the onco-gynecology department with pain and unpleasant sensation in right hypogastric area. Contrast-enhanced CT scan revealed non-contrast-enhancing, nonhomogeneous cystic mass, 10.6 cm in diameter in place of right ovary. 2.7 cm and 2.3 cm masses were visualized in pararectal and presacral areas, embedded in retroperitoneal fat. Ovarian markers were within normal inhibtors as part of treatment for relapsed ovarian cancer. The 71-year-old was diagnosed with high-grade serous ovarian carcinoma (HGSOC), FIGO stage IIIIB, BRCA-1 positive, in 2013 and underwent extensive treatment for almost ten years. First-line therapy included six cycles of carboplatin-paclitaxel plus bevacizumab between January and May, 2013 followed by maintenance therapy with bevacizumab until March, 2014. After relapsing in June, 2017 the patient underwent salvage surgery with complete resection and platinum rechallenge therapy with six cycles of carboplatin-caelyx plus bevacizumab. As maintenance therapy all three PARP-inhibitors were used consecutively from May, 2018 two of which had to be discontinued due to side effects. First niraparib following recurrent thrombocytopenia, then olaparib for abdominal pain. To enable treatment with a PARP-inhibitor, she received rucaparib from October, 2018 until her second relapse in June, 2020. After another salvage surgery with complete resection she was given three cycles of carboplatin and one cycle of cisplatin from September, 2020 to January, 2021. She has received maintenance therapy with rucaparib since March, 2021 with manageable side effects.

**Results** Rucaparib caused a slower and smaller decrease in platelet count. Transaminases only increased slightly without reaching adverse effect level according to CTCAE, making it an asymptomatic laboratory finding.

**Conclusion** This report gives an example of how to manage potential side effects during PARP-inhibitor therapy in routine clinical practice. Even after intolerance of two PARP-inhibitors, another was tolerated, showing that switching PARP-inhibitors during therapy is possible. Patients react differently to side effects of PARP-inhibitors, further studies should focus on predictive clinical and pharmacodynamic parameters to identify individual toxicity for optimization of the efficacy of PARP-inhibitors.
Abstracts

2022-RA-1290-ESGO MAINTENANCE OLAPARIB RECHALLENGE IN PATIENTS WITH OVARIAN CANCER PREVIOUSLY TREATED WITH A PARP INHIBITOR: DETAILED SAFETY RESULTS FROM THE PHASE IIII OReO/ENGOT-Ov38 TRIAL


Introduction/Background OReO/ENGOT-oV38 (NCT03106987) demonstrated a statistically significant progression-free survival benefit with maintenance olaparib rechallenge versus placebo in patients with platinum-sensitive relapsed ovarian cancer (PSROC), irrespective of BRCA1/BRCA2 (BRCA) mutation status. Safety data were consistent with olaparib during first use; overall, olaparib discontinuation due to adverse events (AEs) was low (Pujade-Lauraine et al. ESMO 2021). We further characterised the tolerability of maintenance olaparib rechallenge in OReO/ENGOT-oV38, including time to onset and duration of selected AEs deemed relevant to olaparib.

Methodology Patients with PSROC in response to their most recent platinum-based chemotherapy, who had received one prior maintenance PARP inhibitor, were enrolled into BRCA-mutated or non-BRCA-mutated cohorts. In each cohort, patients were randomised 2:1 to maintenance olaparib (300 mg) or placebo bid until disease progression. Safety and tolerability were assessed in patients receiving ≥1 dose. AEs were monitored during treatment and for 30 days after discontinuation.

Results All 220 enrolled patients were included in the safety analyses (BRCA-mutated, n=112 [olaparib, n=74; placebo, n=38]; non-BRCA-mutated, n=108 [olaparib, n=72; placebo, n=36]). At data cutoff, 8 (7%) and 27 (25%) patients in the BRCA-mutated and non-BRCA-mutated cohorts, respectively, were still receiving treatment. In the BRCA-mutated cohort (olaparib arm), median time to first occurrence of nausea, vomiting, neutropenia, and thrombocytopenia was ≤38 days (table 1). Median durations of first events of nausea, vomiting, neutropenia, and thrombocytopenia were ≤29 days, excluding anaemia (table 2). Duration of first events of nausea, vomiting, neutropenia, and thrombocytopenia was ≤36 days (table 2 for placebo comparison). No cases of MDS/AML were reported (olaparib arm).

Conclusion In patients with PSROC who received maintenance olaparib rechallenge, AEs usually occurred early and were generally manageable, consistent with the known safety profile of olaparib.